• POLICY •
FAMILY COUNCIL
A FAMILY, COMMUNITY & STATE PARTNERSHIP

14th & Jefferson

P.O. Box 45015

Olympia, WA 98504-5015

T: (360) 902.7880

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Differential Help to Fit Unique Community Conditions

(PD)

A multitude of chronic and acute stressors, from hunger and homelessness to child abuse, parental mental illness, and exposure to family violence increase risk of substance abuse, violence, academic failure and disease. For children at critical and sensitive developmental periods, like early childhood, increased exposure to these problems has a lifelong effect on mental, physical and behavioral health.

Family stress is elevated during economic crisis, yet public and private funding for direct services for families and children is reduced. Failure to prevent and intervene effectively, especially during an economic downturn when stressors are high, is highly likely to deliver to the people of Washington an escalation of costs and problems for generations to come.

To minimize these risks, assistance for families and children must include increased levels of informal help from family, friends, and neighbors as well as services that are tailored to local needs, strengths and resources. Although the Family Policy Council is a premier system for increasing informal help, tailoring services, and leveraging resources to improve lives. Currently the Council promotes alignment of resources at the local level based on collaborative agreement (see attachment 1). However, the child and family serving system cannot adapt to meet current demands and prevent future escalation of harm unless state agencies and community partners work in concert to reduce adverse childhood experience and improve resilience.

Community Network leaders report that children increasingly have more complex problems with more severe and challenging consequences (see http://www.fpc.wa.gov/publications/Community%20Context%20Summaries%2009-11.pdf). Cross-system collaboration between and among professionals is needed in order to develop and implement prevention, treatment and social capital supports appropriate for the complexity of the presenting problems unique to each community.

Success & Opportunity

In 1994 the Family Policy Council, impatient for exponential improvements in the rates of major social problems, began systematically investing in two kinds of capacity: 1) capacity to deliver programs with fidelity; and 2) general community capacity to simultaneously reduce the rates of multiple high cost social problems. Our recent research findings show that our success in developing general community capacity is critical to vulnerable people. (See: http://www.fpc.wa.gov/publications/technicalpaper-ver3.pdf.) In the past ten years Family Policy Council community capacity building has significantly reduced caseload costs in child welfare, juvenile justice and teen pregnancy-related health care, and has reduced the rate of dropping out of school in communities focusing on youth development. Among counties with Family Policy Council Community Networks, overall severity of problems decreased or remained stable from 1998-2006 while it worsened for those counties without state-funded Community Networks.

Family Policy Council study findings provide empirical evidence of a threshold above which capacity has the effect of reducing multiple problem rates simultaneously. Our evidence supports the 'tipping point' theory of change which proposes that change efforts produce few small results at first, with exponential change occurring as a community reaches a certain saturation or multiplier point. In the case of Washington communities, rates of more social and health problems are reduced simultaneously as community capacity reaches higher levels. Ten communities have reached this tipping point (labeled *Thriving* below). Given the data we have in hand August, 2010, Family Policy Council would classify twelve more as *persistent*. *Persistent* communities are poised for this transformative shift in the quality of community and family life.

Even in communities impacted by many severe child and family problems, community capacity has powerful effects. Sixteen Community Networks are operating in communities with many major social problems occurring at extremely high rates. The sheer volume of problems requiring response from law enforcement, health care and others floods the system obfuscating the path from current conditions to thriving. Professionals are hard pressed to choose just one or two for concentrated collaborative focus. A comprehensive and strategic theory of change is needed, yet they are the very communities that find it most difficult to co-create such a theory.

The Family Policy Council has been successful at helping communities with very severe problems, including distressed rural and Tribal communities, to reach the tipping point where multiple problems plummet. Success takes an infusion of resources, intensive on-site assistance, and a coordinated and intentional effort that is sensitive to and tailored for each community's strengths and challenges.

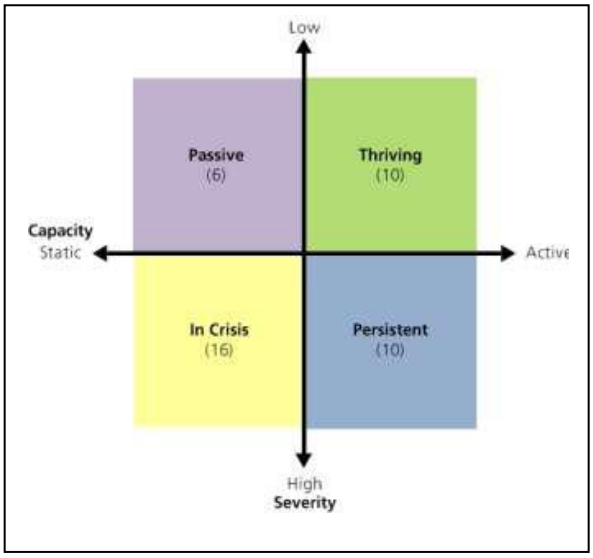
Adverse Childhood Experiences

Since 1999, the Family Policy Council has implemented a unique education strategy to support each Community Network in expanding knowledge and collaboration. Because we work to reduce the rates of seven different social problems, and each of these has a separate and distinct research literature, the Family Policy Council developed an education framework that unifies the work of many partners and helps them to create comprehensive community strategies for helping children and families to thrive. This framework includes education about developmental neurobiology, the Adverse Childhood Experience Study, resilience research, and systems thinking. Adverse Childhood Experiences (ACE), the most powerful determinate of the public's health, has become a cornerstone for understanding interrelated problems behaviors, and linking childhood experiences to long-term health and behavior outcomes. The original study findings include the fact that ACEs are common, and have a cumulative impact on health. The number of different categories of ACE (ACE score) – not the intensity or frequency of a single category – determines numerous differently mental, physical and behavioral health outcomes.

Method for Matching Support to Community Conditions

The Family Policy Council considers two factors when matching supports to a community: general community capacity, and problem severity. Problem severity is defined as having many separate social and/or health problems occurring at very high rates (in the worst quartile of county rates). All communities are "ready to benefit." The issue that funders need to consider together is: ready to benefit from what? What next steps will have the most dramatic positive effects so that every community reaches and sustains community capacity at the tipping point?

Due to community variance in both community capacity to solve problems and problem severity, the Family Policy Council model for helping communities provides for different kinds of assistance for each of four distinct clusters of communities. In April of 2009, Family Policy Council staff designated each community we serve into one of four severity/capacity categories:

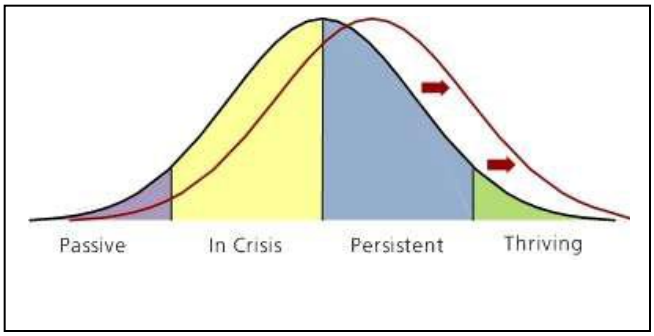


1 *Passive*: Six Community Networks were operating in communities with few severe rates coupled with static community capacity. These communities need data analysis and other technical supports that help them recognize children at risk and activate their commitment. These communities also benefit from opportunities to pilot new ways of doing business that can energize and mobilize leaders. The total population of the *Passive* cluster of communities was 879,426.

2 *In Crisis*: Sixteen Community Networks were operating in communities with many very severe problems and insufficient community capacity to build comprehensive sustainable strategies that improve resilience, reduce violence and reduce intergenerational transmission of ACE. Flooded with problems, these communities need intensive hands-on technical, education and financial help. Despite immense pressures, impressive gains in community capacity are occurring. The total population of the *In-Crisis* cluster of communities was 1,471,873.

3 *Persistent*: Ten Community Networks were operating in communities where multiple high rates persist. However, leaders are generating very active community capacity dynamic. We believe that these communities are close to the tipping point where multiple rates come down. These communities need on-site resources, education, a deeper understanding of how the highest levels of capacity are achieved, cross-training of professionals so they can participate

in whole-community strategy development and implementation, and opportunity to create new policy, protocols, and practices tailored to population strengths and needs. The total population of the *Persistent* cluster of communities was 1,971,127.



4 *Thriving*: Ten Community Networks were "best performers". Multiple rates are coming down and they are operating in communities with very active community capacity dynamics. It is in the state's interest to support these communities to stay out in front – learning together, building new models that save money, and helping other communities. The total population of the *Thriving* cluster of communities was 1,549,874.

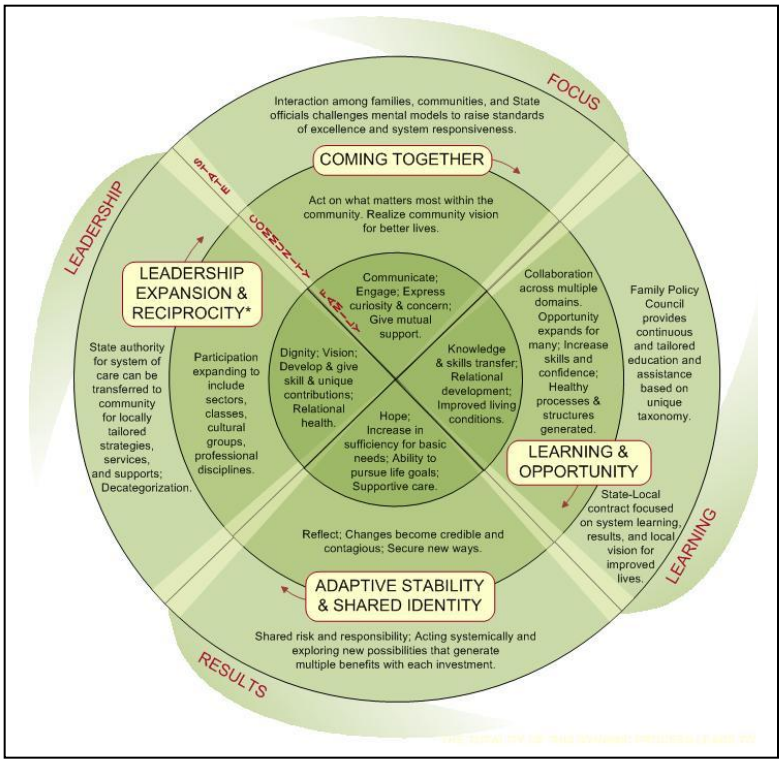
Family Policy Council staff recommends strategic investments for each of these clusters tailored to decrease the risk of violence in the economic downturn and move the state as a whole toward thriving. However, caution should be taken as we tailor investments. Every community is changing all the time. Classification of communities by this, or any other, means is done through indicators of strength and challenge – indicators that are only a puny shadow of the real community dynamics. Plus, there may be pockets of each community that are functioning much better than other pockets; and these categories are made based on large geographic areas. Changing dynamics plus the challenges of using indicator data to understand a community's strengths and readiness make classification tenuous. Continuous communication with community leaders and among funders is necessary in order to generate understanding that can lead to a 'right fit' between resource allocation and the needs and capacity of each community.

Community Capacity Development Model

Community capacity is an emerging academic field. Since the Family Policy Council Community Networks have engaged in organized and systematic measurement of community capacity since their inception, the partnership is able to contribute significantly to that field. General capacity refers to skills, characteristics, and the overall functioning associated with the ability to implement or improve any innovation. At its core, general community capacity is the ability of the community to identify and address or prevent existing problems (Flaspohler, 2008).

Communities are capacity building when they are continuously and collaboratively learning and improving their ability to function effectively. The Family Policy Council's attention to long term outcomes supported by outcome focused contracts plus education investments that support and challenge local leaders to engage in critical thinking, participatory evaluation, dialogue and review resource prioritization are all designed to promote and require community capacity building.

The Family Policy Council *Community Capacity Development Model* illustrates the fundamental processes of community capacity building for families, communities and funders. The model also illustrates how these processes interrelate and reinforce one another to generate sustainable and exponential improvements in child and family life. The Family Policy Council model articulates a virtuous reinforcing set of processes. Each one, in turn, improves the strength of, and engagement in, the subsequent process in the model. (A more complete version of the model is in attachment 2.)
Community Networks use this iterative process to achieve the following.



1. Bring together community and uncommon partners to build a common language, overcome denial, and act on what matters most locally.
2. Learn the costs and causes of problems through collaboration across multiple domains

to expand skills, confidence and determination.

3. Share risk and responsibility in measuring outcomes and achieving desired results. Monitor and build upon changes to attitude, behavior and policy.
4. Expand participation and renew natural leadership roles that are credible and contagious.

Measuring Community Capacity

The Family Policy Council *Community Capacity Index*, assessed every two year, highlights four dimensions that both research and practice suggest are most important. Community capacity is rated every other year by a set of external reviewers based on reports submitted to the Family Policy Council from Community Networks. (The rating sheet is attached.) These reports are about the strategic investments of many organizations – the overall community strategy for improving child and family outcomes. A community capacity index was computed by averaging the independent ratings of the different reviewers across the four measurement categories: focus, learning, results, and leadership. An analysis of recent ratings showed good inter-rater reliability among the reviewers.

Focus: Commitment to convening strategic, results-based alignments using community-based participatory research and a shared vision of community wellness.

Learning: Formal and informal education opportunities informed by local conditions and experiences that are changing and create conditions for innovation, which includes opportunities to network, reflect and share information in formal and informal ways.

Results: Maintain and improve evaluation of new conditions and new practices and policies that generate multiple benefits with each investment.

Leadership: Expand and diversify participation that permeates boundaries and bust barriers to include all social economic and political sectors, cultural groups and professional domains.

Measuring Problem Severity

Investment in the Family Policy Council model for improving Community Capacity has resulted in significant rate reduction and cost savings for the state as a whole. However, communities vary greatly in the number and severity of problems they face and in the resources available to them. Problem severity – having many problems with rates that fall in the worst quartile of rates statewide – can hamper or complicate the local task to improve the lives of children and families because overlapping and interacting problems seem overwhelming and elusive.

Severity Index

The Family Policy Council *Severity Index* for communities considers how high rates of separate and distinct problems pile-up in communities, which is consistent with the way the ACE study considered how separate and distinct adverse experience categories pile-up during human development and generate cumulative impacts on health.

Using 15 archival indicators of child and family problems related to Adverse Childhood Experiences (ACE), the Family Policy Council created a *Severity Index* of cumulative risk/stress at the community level, and mapped severity scores by county throughout Washington State. Three year rolling averages were computed to increase the stability of rates for each indicator. We use indicators that are readily available for counties across the state from 1998 to 2006 include. The severity score is the number of problems occurring in at very high rates – in the worst quartile or quintile of county rate.

Archival indicators include the following.

- Safety – Injury hospitalizations (birth to 17), out-of-home placements, terminations of parental rights, filing for juvenile offence, youth arrests for violent crime and weapons incidents at school. (Reliable measure of domestic violence not available.)
- Health – low birth weight, infant mortality, no third trimester care, teen mothers and teen suicide attempts.
- Development – Arrests for alcohol and arrests for drugs.
- Learning – Low performance on Grade 4 WASL and High School dropout (yearly average dropout and freshman to high school dropout rates.)

Interagency Dialogue

Mapping of severity and capacity prompted inter-agency dialogue: Do state agencies need to be different kinds of partners in places with many ACE-related problems are occurring at extremely high rates? Are we perpetuating a system tendency to reinforce success to the successful at the expense of high severity neglect? How might we work together to improve the fit between the kind of help we provide to a community and the community's severity and capacity?

Severity and Capacity Score Updates

The Family Policy Council worked with the Department of Health to gather information about Adverse Childhood Experience scores among adults throughout Washington in 2009 and again in 2010. Adverse Childhood experience is the most powerful determinate of the public's mental, physical and behavioral health (see http://www.acestudy.org/ and http://www.cdc.gov/nccdphp/ace/).

Updates of severity and capacity scores will be complete by January, 2011. By that time the Family Policy Council will be able to incorporate 2007 and 2008 archival data, and will have analysis of 2009 Adverse Childhood Experience data by clusters of counties. We will use these data, and others as they become available, to expand the Severity Index as a way to learn about problem severity in communities throughout the state. By 2012, we will have county –level data for ACES in all but the tiniest of counties. The Council will also have a new round of scores for community capacity based on independent evaluation of reports from the 2007-2009 biennium.

Severity & Capacity Research

Through the recent examination of Community Network community capacity building and community rate reduction, we see an exciting pattern and a promising tipping point or threshold above which problem rate reductions occur exponentially. Supported by eight years of reporting, 1998 to 2006, Family Policy Council Research Director, Dr. Dario Longhi, conducted studies of the relationship between community capacity and improvements in child, family and community life. This research documents that Community Networks engage residents and professionals to focus on root causes to foster shared learning, generate leadership expansion, and hold high expectations for service and service outcome improvements. They set the course for reaching a community capacity tipping point where:

<u>Foundations for Healthy Development Improve</u>

1. Five or more different problem rates come down – indicating improved health, safety and prosperity for the population as a whole. (http://www.fpc.wa.gov/publications/technicalpaper-ver3.pdf)

<u>ACE Score Is Reduced from One Generation to the Next</u>

2. The average ACE score of youth transitioning into adulthood and parenthood is reduced. Fewer people have 3 or more ACEs, thus preventing many mental, physical and behavioral health problems throughout their lifetime. (http://www.fpc.wa.gov/publications/Relationship%20between%20ACEs%20and%20%20BH%20and%20PH%20%206%2024%2010.FINAL.pdf)

<u>Improved Social Responses to High ACE People Result in More Joyful, Fulfilling & Productive Lives</u>

3. In High Capacity communities, youth who have experienced Adverse Childhood Experiences are much less likely to use alcohol, marijuana and tobacco; thereby dramatically reducing their risk for disease, disability and problems at work, home and community. (http://www.fpc.wa.gov/publications/FPC_High%20Risk%20Protect%20Youth_Nov%2009.pdf & http://www.fpc.wa.gov/publications/FPC_Social-Normative%20High%20Risk%20High%20Capacity_Dec%2009.pdf)

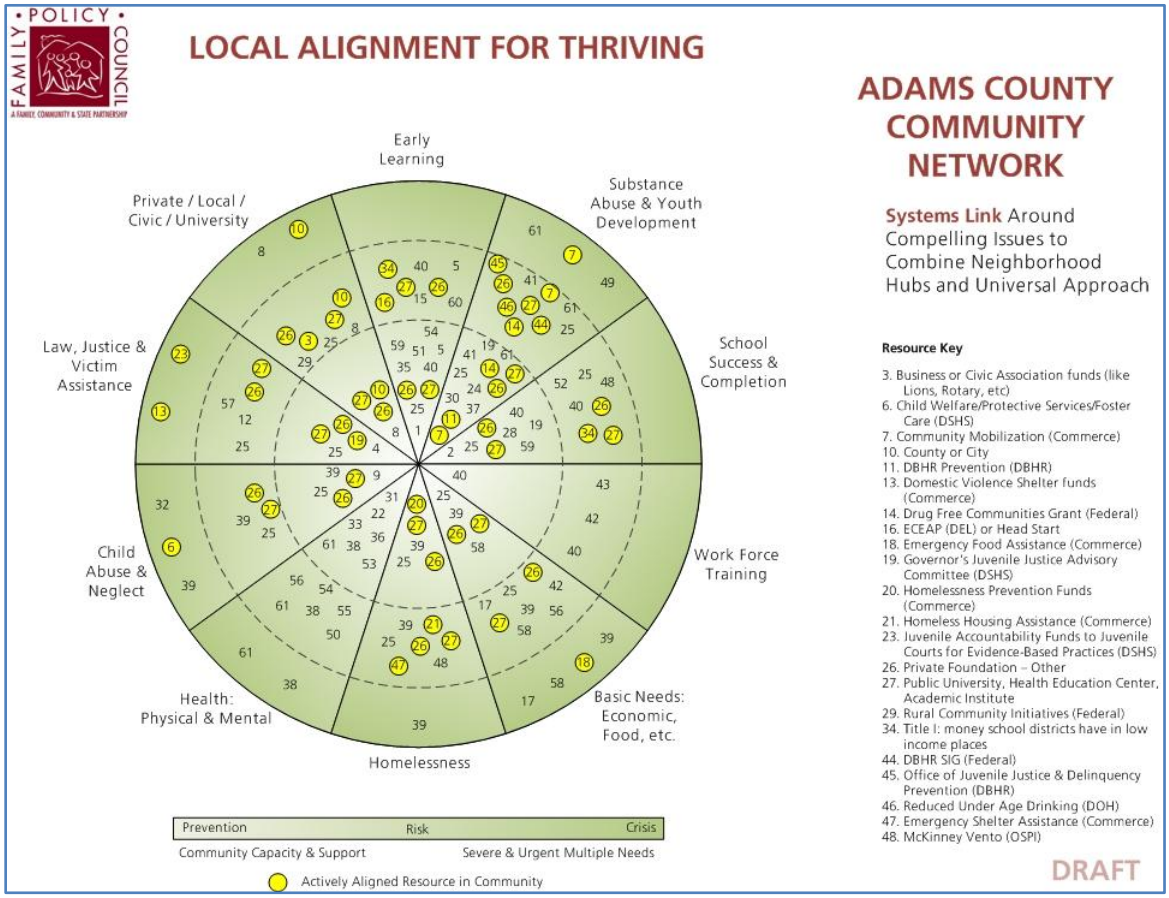
Conclusion

Providing differential help to communities based on severity and capacity holds vast potential which includes significant savings to life, health, and government and business costs.

High Capacity Communities Align & Focus Resources, Improve Multiple Outcomes

The Family Policy Council has been mapping the local alignment of resources in communities with Community Networks to illustrate the diverse linkages that have been established across agencies and funders at the local level. The specific resources that each community aligns varies. This variation is the product of many factors: community conditions; history and culture; available non-cash resources; success winning grants; locally-developed theory of change about how actions will lead to results; and the issues and possibilities that motivate residents to give time, expertise, and other resources.

Example:
In Adams County, systems link around compelling issues to combine people-powered neighborhood hubs with a universal approach to service system improvements. Actively aligned resources in the community produce the following pattern:

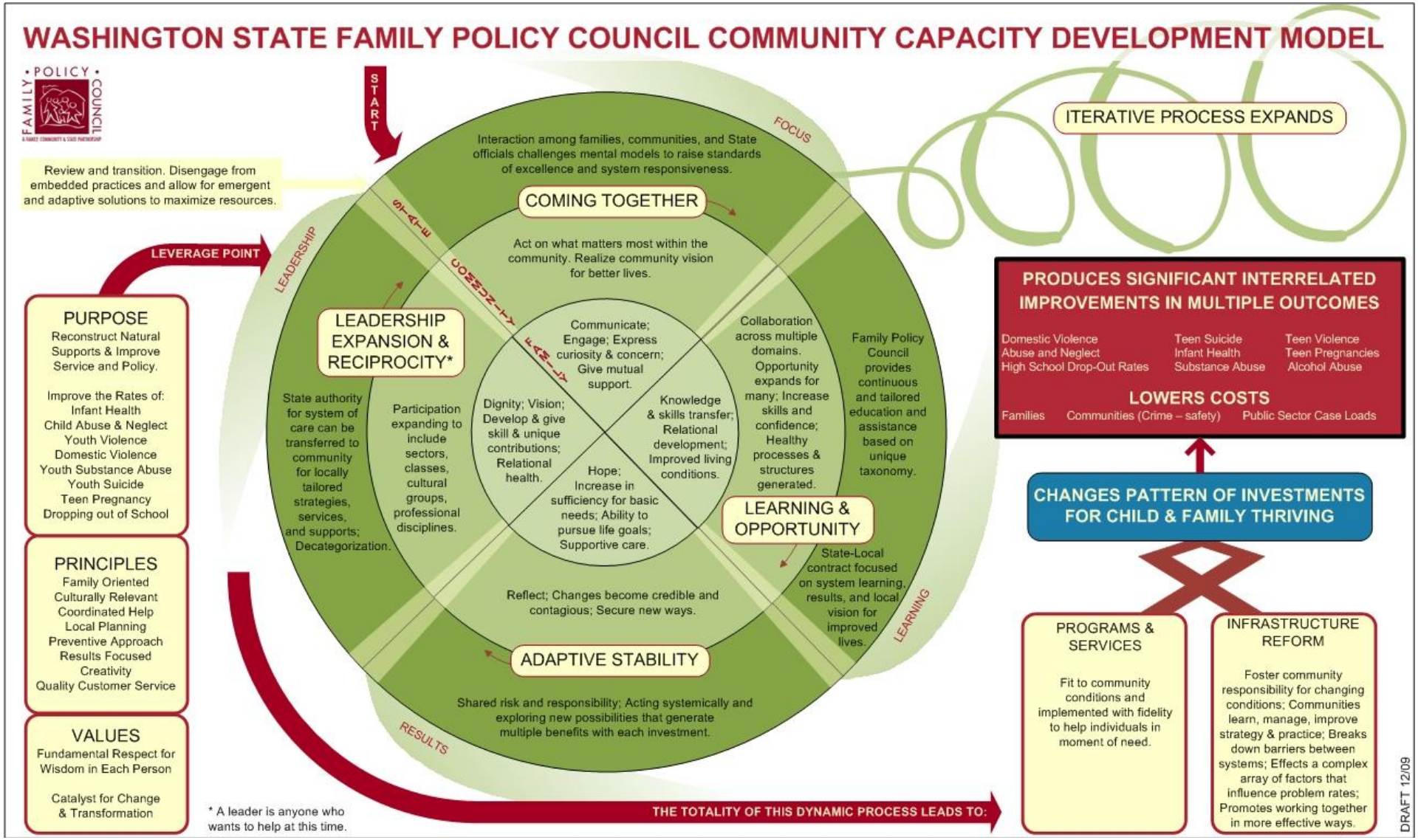


At the September Regional Dialogue Adams County Community Network Coordinator, Barbara Anderson, explained the process of connecting issues locally to support a deeper understanding of community need and opportunity. In recent years, due to her track record, Barbara began to face a positive problem: her extremely successful fundraising and the community's strategic action agenda improved problem rates enough over the past decade that Adams county grants no longer win highest scores for community need. Also, grant resources are few and these resouces are now targeted to address recession-related issues. Noticing those patterns informed Barbara's work (*emergence*) and invited the community to come together to consider re-thinking how their strategies now fits with external realities (*co-evolution*).

Barbara reconnected with a common core value Adams County residents hold: safe community living. With this message, Barbara started at the most powerful foundation of the Iceberg – values. She brought people together to talk about whether their core value had been fully realized. When we look at Adams County life using a 360 degree view – have we achieved safe community living for all? Residents were not satisfied – they wanted life to better reflect their

commitment to safe community living. They began to explore ideas about new pathways for action. Dialogue led to unprecedented ways of thinking, which led to alignment of a wider array of resources. Barbara explains the process of connecting issues locally to support a deeper understanding of community need:

> "We took a look at some of those areas that put kids at risk for juvenile violence and delinquency and some of those areas are early school failure and another area…was coming to school prepared to learn. That led us right back to, are they coming from a quality home, are they even coming from a home at all? That led us, five years ago, to take a look at homelessness and low and behold there was a little dab of money available for homelessness.
>
> "Since then we've built three emergency shelters, we've developed a homeless strategic 10 year plan, I mean the list goes on. We are in the process of looking at transitional housing, we're going to manage the homeless prevention rapid recovery funding for the Department of Commerce, we're gonna manage the emergency shelter assistance and homeless prevention grant from the Department of Commerce, so the list goes on. We could not have done that had we not have had the partners in place to be able to – and the partners stem from the original work in the prevention of teen substance abuse and our original work in juvenile violence and delinquency and still, I want to get back, its full circle, our homelessness project is a juvenile violence and delinquency prevention project, it relates back to our mission statement. "


WASHINGTON STATE FAMILY POLICY COUNCIL COMMUNITY CAPACITY DEVELOPMENT MODEL
FAMILY POLICY COUNCIL
START
Review and transition. Disengage from embedded practices and allow for emergent and adaptive solutions to maximize resources.
LEVERAGE POINT
PURPOSE
Reconstruct Natural Supports & Improve Service and Policy.
Improve the Rates of:
Infant Health
Child Abuse & Neglect
Youth Violence
Domestic Violence
Youth Substance Abuse
Youth Suicide
Teen Pregnancy
Dropping out of School
PRINCIPLES
Family Oriented
Culturally Relevant
Coordinated Help
Local Planning
Preventive Approach
Results Focused
Creativity
Quality Customer Service
VALUES
Fundamental Respect for Wisdom in Each Person
Catalyst for Change & Transformation
FOCUS
Interaction among families, communities, and State officials challenges mental models to raise standards of excellence and system responsiveness.
COMING TOGETHER
Act on what matters most within the community. Realize community vision for better lives.
LEADERSHIP
LEADERSHIP EXPANSION & RECIPROCITY*
State authority for system of care can be transferred to community for locally tailored strategies, services, and supports; Decategorization.
Participation expanding to include sectors, classes, cultural groups, professional disciplines.
Communicate; Engage; Express curiosity & concern; Give mutual support.
Dignity; Vision; Develop & give skill & unique contributions; Relational health.
Knowledge & skills transfer; Relational development; Improved living conditions.
Hope; Increase in sufficiency for basic needs; Ability to pursue life goals; Supportive care.
Collaboration across multiple domains. Opportunity expands for many; Increase skills and confidence; Healthy processes & structures generated.
LEARNING & OPPORTUNITY
Family Policy Council provides continuous and tailored education and assistance based on unique taxonomy.
State-Local contract focused on system learning, results, and local vision for improved lives.
LEARNING
Reflect; Changes become credible and contagious; Secure new ways.
ADAPTIVE STABILITY
Shared risk and responsibility; Acting systemically and exploring new possibilities that generate multiple benefits with each investment.
RESULTS
* A leader is anyone who wants to help at this time.
THE TOTALITY OF THIS DYNAMIC PROCESS LEADS TO:
ITERATIVE PROCESS EXPANDS
PRODUCES SIGNIFICANT INTERRELATED IMPROVEMENTS IN MULTIPLE OUTCOMES
Domestic Violence
Abuse and Neglect
High School Drop-Out Rates
Teen Suicide
Infant Health
Substance Abuse
Teen Violence
Teen Pregnancies
Alcohol Abuse
LOWERS COSTS
Families
Communities (Crime – safety)
Public Sector Case Loads
CHANGES PATTERN OF INVESTMENTS FOR CHILD & FAMILY THRIVING
PROGRAMS & SERVICES
Fit to community conditions and implemented with fidelity to help individuals in moment of need.
INFRASTRUCTURE REFORM
Foster community responsibility for changing conditions; Communities learn, manage, improve strategy & practice; Breaks down barriers between systems; Effects a complex array of factors that influence problem rates; Promotes working together in more effective ways.
DRAFT 12/09

Family Policy Council

Community Capacity Index

Rating Sheet

Attachment 3

Name of Network_____ **Total Score** _____ Reader's initials & Date _____

Rate work on scale 1 (low) to 5 (high)

A. FOCUS ON RESULTS

1. The Network reports a body of work or strategic effort rather than single projects. _____
2. Measurable results are reported and verifiable. _____
3. Results are tied to community values/intentions as demonstrated by the link to the Network comprehensive plan and/or collaboration in the work being considered. _____
4. Network can demonstrate a logical link between current results and long-term reduction of problem behaviors. _____

Total Results Score [ ]

B. LEARNING

1. Network demonstrates and can articulate its own learning. (Analyzing data, making changes based on experience.) _____
2. Network draws connections between proposed projects and knowledge or research related to problem behaviors and related risk and protective asset or resiliency factors. _____

Total Learning Score [ ]

C. COMMUNITY STRATEGIC LEADERSHIP _____

1. Efforts are clearly linked to Network strategic plan. _____
2. The work reflects meaningful community collaboration.
3. Network provides leadership in the community as demonstrated by community involvement in strategic planning, implementing the plan or leveraging resources. _____
4. The Network is able to leverage resources through partnerships, grants and/or selection of pilot programs that are later funded or replicated by others. _____
5. Efforts show signs of being either replicable or institutionalized within the community OR efforts result in resolution of a defined community issue. _____
6. The community demonstrates support for Network efforts. (Board membership, event participation, program evaluation, etc.) _____

Total Strategic Leadership Score [ ]

D. COMMUNITY OUTCOMES

1. Intermediate and long term outcomes are stated clearly in writing, outcome measurement methodology improves over time, and results are useful and credible for helping the community develop strategic system and program improvements. _____
2. The community tracks indicators of “at risk” behavior rate indicators, and engages in public dialogue about how to reduce the rates of “at risk behaviors”.
3. There is a positive correlation between the degree to which the community network has focused on reduction of a particular “at risk behavior” and indicator(s) of the rate of that behavior. _____

Total Community Outcomes Score [ ]

TOTAL SCORE ALL AREAS (transfer to top) [ ]

Adverse Childhood Experience (ACE[i]) Related Indicators in Counties[ii] with State Funded Family Policy Council Community Networks[iii]

ACE Category	Related Archival Indicator	Funded High Severity Counties: Okanogan	Mason	Benton	Grays Harbor	Grant	Garfield	Franklin	Cowlitz	Clallam	Yakima	Unfunded Counties: Whatcom	Stevens	Skagit	Pend Oreille	Pacific	Lincoln	Lewis	Ferry	Columbia	Funded Counties: Whitman	Walla Walla	Whatcom	Thurston	Spokane	Snohomish	Skamania	San Juan	Pierce	Island	King	Kitsap	Jefferson	Grays Harbor	Clark	Douglas	Chelan	Benton	Adams
Child Abuse /Neglect	Parental Rights Termination				X				X		X			X	X	X			X	X			X															
	Dependencies		X		X					X			X	X		X				X		X	X															
	Youth Reports - Have Been Abused (2006 only - trend data not available as of the publication date)		X	X			X	X	X							X		X		X				X									X				
	Hospitalizations (Birth to 17)						X				X		X		X	X	X			X				X			X											
Mentally Ill, Depressed, or Suicidal Person in Home	Youth in Transition Using Medicaid Mental Health Services as % of Total Age 16-25 Population (2007 only)	X		X					X		X				X	X		X	X	X			X														
	Youth Reports – Seriously Considered Suicide, Past 12 Months (2006 only)		X			X	X	X	X	X	X					X		X		X															X		
	Suicide Attempt Hospitalizations (youth)	X					X	X	X		X						X			X			X					X									X
Drug Addicted or Alcoholic Family Member	Arrests for Alcohol Violation (ages 10-17)	X			X	X	X			X	X									X								X				X					X
	Youth in Transition Using Medicaid Drug Treatment Services as % of Total Age 16-25 Population (2007 only)	X	X	X	X					X	X	X				X			X	X												X					
	Arrests for Drug Violation (ages 10-17)	X		X				X	X	X		X																				X			X	X	X	
Witnessing Domestic Violence Against Mother	Youth Reports – Have Seen Adult to Adult Violence (2006 only- need data over time)	X		X	X	X			X							X		X	X				X				X										
	Women Injury Hospitalizations[v]		X		X	X				X	X					X		X					X	X														
Incarceration- Any Family Member	Children with Ever Incarcerated Parent		~[v]		#[vi]				#	~		~						#	~						~													
	Registered Sex Offenders[vii]	X	X	X	X				X						X			X	X			X		X				X		X								
	Arrests for Violent Crime	X	X					X	X	X	X							X		X									X									X
	Filed Juvenile Offenses	X		X		X			*[viii]	X		X				X				X							X								X	X	X	
Loss of a Parent	(Data not captured as of date of publication)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
OTHER - NON ACE STUDY																																						
Sense of Safety	Youth Reports – Feel Unsafe in Boyfriend or Girlfriend Relationship (2006 only)		X	X				X	X	X						X			X	X												X		X			
	Weapons Incidents in School		X		X			X	X			X		X							X							X						X				X
Infant Health	Low Birth Weight			X				X			X	X	X				X		X			X						X								X		
	Infant Mortalities	X	X						X		X	X		X				X	X									X								X		X
	No Third Trimester Care	X			X	X		X							X	X			X													X				X		X
	Births to Mothers 10-17		X		X	X		X	X		X			X				X															X				X
Education	ESPT Dropout Out of School [ix]	X			X	X		X		X	X			X		X		X			X							X	X								
	Difference of Freshman and Senior Class Size	X			X	X		X			X					X	X		X									X								X		

Trend is worsening '98-'06
In worst quartile, but trend is not worsening '98-'06
In worst quartile, no trend data available at time of publication
Data not in worst quartile

[i] This epidemiological study, called the adverse childhood experiences (ACE) study, was conducted between 1994 and 1997 by the Centers for Disease Control and Kaiser Permanente San Diego. There were over 17,000 participants in the study. Each participant was asked 70 questions about their childhood experiences and then their health records were used to identify health outcomes. The adverse childhood experiences questions came from existing standardized instruments. The researchers did ask about severity of abuse, duration and other kinds of questions that are important to folks working in child safety. But when it comes to mental, physical and behavioral health outcomes, they found that what matters is the number of kinds of adverse childhood experiences.

[ii] This analysis is limited to counties because limited Family Policy Council financial resources results in limited availability of this large a list of indicators at lower geography (school district, zip code) in sub county areas. There may be areas in counties not listed here that have high severity. For example, King County Public Health data suggests that South Seattle and some parts of South King County may also have high severity. This particular set of counties was selected based on having five or more accumulative high rates of major social problem indicators.

[iii] Counties that do not have a state-funded Family Policy Council Community Network, and therefore do not have data analysis for this report are: Ferry, Stevens, Pend Oreille, Lincoln, and Whitman counties.

[iv] Data reflects a five year average, 2003-2005, with no trend data available. X signifies that all or a significant portion of the county rate is one or more standard deviations above the state rate

[v] ~ symbol signifies that the county rate is in the second to the worst quintile as compared with other county rates; quartile data isn't readily available at the time of this publication

[vi] # symbol signifies that the county rate is in the worst quintile as compared with other county rates; quartile data isn't readily available at the time of this publication

[vii] Registered sex offenders per thousand population in 2007; trend data not available at the time of this publication

[viii] Cowlitz County Commissioners reported a 75% youth crime recidivism rate in May 2009 interview.

[ix] Data reflects a five year average, 2003-2005, with no trend data available. X signifies that all or a significant portion of the county rate is one or more standard deviations above the state rate

[x] Registered sex offenders per thousand population in 2007; trend data not available at the time of this publication

For additional information, please contact:
Laura Porter
Staff Director
Washington State Family Policy Council
360-902-7880
fpc@dshs.wa.gov